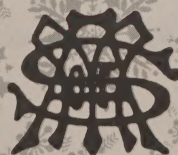


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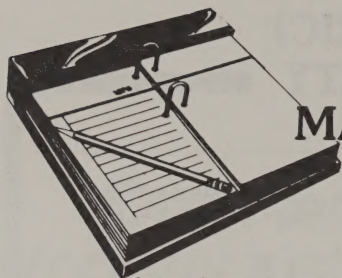
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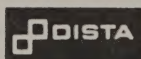
American Association of Foundations for Medical Care  
Regional Meeting on I.P.A.'s Boston, May 24-26, 1979

|                               |                                           |
|-------------------------------|-------------------------------------------|
| Executive Meeting of H.D.M.S. | January 19, 1979                          |
| Executive Meeting of H.D.M.S. | February 20, 1979                         |
| District Meeting of H.D.M.S.  | February 6, 1979 Marriott Hotel           |
| Pre-Council Meeting           | January 4, 1979                           |
| A.M.A. Leadership             | February 15-18, 1979 Chicago,<br>Marriott |
| Council Meeting M.M.S.        | February 14, 1979                         |

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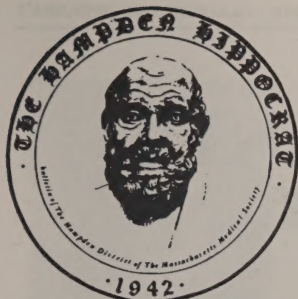


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The official bulletin  
for The Hampden District  
of The Massachusetts  
Medical Society.

Founded in 1942 by  
Edward P. Bagg, Jr., M.D. and  
William A. R. Chapin, M.D.

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THE OPINIONS EXPRESSED IN THIS BULLETIN ARE THOSE OF THE WRITERS AND DO NOT REFLECT THE OFFICIAL VIEWPOINT OF THE HAMPDEN DISTRICT MEDICAL SOCIETY UNLESS SO STATED.

ALL COMMUNICATIONS SHOULD BE ADDRESSED TO VIVIAN M. PURDY, HAMPDEN DISTRICT MEDICAL SOCIETY, 1414 STATE ST., SPRINGFIELD, MASS. 01109; TELEPHONE: 736-0661.

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## PRESIDENT'S PAGE

The FTC with simplistic logic has determined that it is appropriate - maybe even desirable - that physicians advertize. Some have reasoned that, in the great American tradition, advertizing will stimulate competition; competition, in turn, will lower prices. Perhaps those of us, who can remember the halcyon days when gasoline was abundant, will visualize a price war on pyloroplasties.

It is unfortunate that, when a government planner has an idea; he or she has difficulty in suppressing enthusiasm - to the point that the idea - proposal - recommendation or whatever must be tried everywhere. The concept of the "test market" trying the thing out in a small area to see if the result achieved is the result expected, hasn't taken very deep root in the thinking of our social planners.

Advertizing by physicians may just not be the boon to economy in medical costs which some think. There is little need for the doctor to advertize lower prices since, in many if not most instances, the patient or consumer is not picking up the tab. So the thrust of advertizing may well be in the direction of more elaborate and expensive treatment - the need for which may be marginal.

Does advertizing do much for the esteem of the medical profession? Hippocrates thought not. The traditional way that the physician and his art have become known in the community has been by the entering of the new doctor into the mainstream of the medical and civic community - by being recognized by one's medical peers as a skillful practitioner of the art and by one's fellow citizens as a valued member of the community. We live in a world of change - but does this too have to change? □

**JOHN J. FLAHIVE, M.D.**

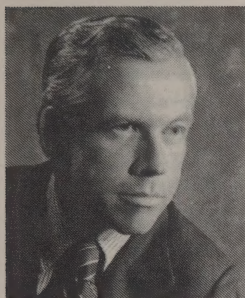


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## THE CHALLENGE OF REALITY

When history is written it seems quite likely that the 70's will be labeled the "Era of Accountability". Now as never before, traditions and positions are being scrutinized, questioned, and even ridiculed by a public, or at least a segment of that public, who appears to believe in the ascendancy of individual rights in society. Consequently, the credibility of the medical profession with the public is now going to rest squarely upon its accountability to that public. No longer can the profession maintain a position of all prevading paternalism toward the public.

It is irrational to deny the need for some alteration in the manner in which medical care is rendered and re-compensed when there are twenty two million Americans who either can't get good prompt health care, or afford to pay for it after they get it. The public is not interested in a recitation of how good our health system is, of how most people already have some form of health insurance, or of how much life styles interfere with good health. They are only interested in how to get universal care. If the physician fails to show the way, it is little wonder that the government believes it is their responsibility to fill the gap. Society has gone too far in determining health care to be a right, for the profession not to recognize its clear responsibility in assuring quality care for all who need it at a cost all can afford. If to do this requires some form of National Health Insurance program, and it now appears, in the absence of a dramatic change in events, that this is more than likely, then the profession had better be on the inside, guiding, prodding, and restraining the bureaucracy. Stubborn resistance to inevitable events rarely if ever, serves any useful purpose.

It is also irrational to deny the legitimate interest of the government in regulating the activities of a profession which utilizes 8.7% of the gross national product and 10% of the entire federal budget. Like it or

*Landen-True*

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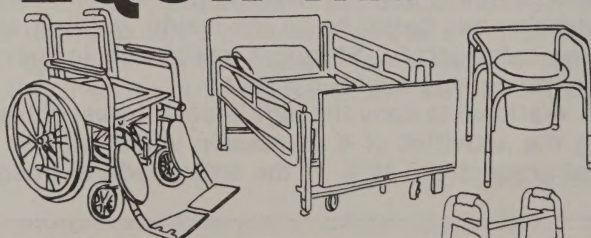
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not, the federal government now supplies 70% of all funds for research, 60% of the cost of physician education, and 40% of all payments for health services and supplies. The fact is that health is one of the most heavily subsidized industries in the country. Understandably, with this public investment, there is clear evidence of a drive for greater control of the practice of medicine, not necessarily for the purpose of making it better, but to make it more uniform and controllable. One can only speculate on the political power to be gained by such endeavors! Nonetheless, the government has a responsibility to regulate, and the profession a responsibility to be accountable. The independence the profession so enjoyed for so long also has fallen victim to social realities, and unless the profession recognizes and deals with this loss of independence, it can expect little attention from the government, or indeed the public.

And most difficult of all, it is irrational to perceive of the medical profession as separate and apart from the pressures of ethical changes in an evolving society. Ethics are not immutable principles which when once enunciated, stand for all times. Medical ethics have steadily developed and been modified since the time of Hippocrates, the last being at the A.M.A. House of Delegates Meeting in 1957. Medicine like all other professions, is and must be, sensitive to changes around it. It is tempting to think of the profession as going on forever, clinging to sacred standards of conduct, but it is also easy to miss the distinction between profession and function. Clearly the function will continue, but the profession may be destroyed, or indeed destroy itself, depending

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upon its response to the dissatisfaction now being expressed in so many diverse ways by those outside the profession. To ignore or stubbornly oppose limited licensed practitioners which the public has seen fit to embrace, or to ignore or resist the mandate toward restrained advertising is to fly in the face of reality. Public bodies have made the determinations and how can the profession have the consummate paternalism to say they are wrong, and we know best. Perhaps it is time to recognize that the public does have the right "to go to hell medically" if it wants. Our role should not be to help them, but neither should the professional fail to respond to that clear and definite challenge. The ethical issues are infinite in their ramifications, and no rational discussion will suffice to settle these issues. The profession must be responsive and responsible to the times in which it exists.

The tragedy of American Medicine may well be that while quick to accept scientific changes, the profession could not adapt to the social consequences of those changes. The profession need not abandon principle but, it does need to face reality, squarely and unafraid, recognizing that opposition without viable alternatives to clearly existing problems is no longer possible. The ultimate challenge is before us; either we move with the society toward more rational solutions to common problems, or we continue the independence of the past, leading to the ultimate bankruptcy of the health care system. Paradoxically, our problems of today reflect the successes of yesterday. Tomorrow, all should be able to enjoy those resources. It is our decision and we have little time left in which to make it. ☐

**JAMES S. TODD, M.D.**

Chairman of the Board,  
The Medical Society of New Jersey  
Delegate A.M.A.  
Chairman, Ad Hoc Committee to REview  
The Principles of Medical Ethics.

*Although Dr. Todd is now a resident of New Jersey he was born in Hyannis, Massachusetts and attended Harvard College and Harvard Medical School thus making him close to Massachusetts.*

*Dr. Todd spent most of his internship and resident program at Columbia Presbyterian Medical Center in New York. He is active in medical society work in New Jersey and practices Vascular surgery in Ridgewood, New Jersey.* ☐

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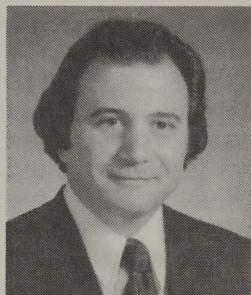


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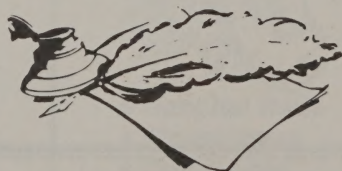


## EMERGENCY MEDICAL CARE

### A SUCCESS STORY

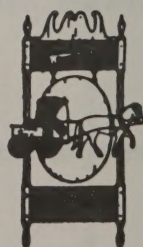
The word "change" is defined by the Webster's Dictionary as: "to make different in some particular: to make radically different: to give a different position, course or direction to". Change is ever present in our lives and in every phase of our existence, be it personal or professional. However, we are all creatures of habit, and change brings about the threat of the unknown. Yet, once we comprehend change, the threat subsides and the change is accepted. Indeed, the manner in which change is accepted varies in a multitude of ways. First, who is accepting the change; who is personally affected by the change; who is economically affected by the change; what are the long range ramifications of the change. In life we usually make changes because there is a need present. Change will remain in place and be successful only if the need is filled. Emergency medical care is a success because it has filled a need. A need that is broad in scope and demanding of service.

The evolution of hospital emergency medicine may be traced back to the words EMERGENCY ROOM. Usually a small room on the first floor or basement of a hospital, in the back of the building where an ambulance or station wagon could pull up to deliver a patient. Medical coverage usually began with the patient coming to the hospital EMERGENCY ROOM and ringing a doorbell to alert someone that there was an emergency. This information was then passed onto the nursing supervisor who would screen the case and would follow the



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appropriate protocol to initiate medical help. This usually involved the calling of a physician on emergency call that day from his office, house or recreation.

The sophistication of this early system varied for several reasons, namely, geography, population, type of hospital, community awareness, education, and need. As anything else, need demanded change. How fortunate we are that about fifteen years ago two groups of physicians, one in the east and one in the midwest, at the same time, and not knowing each other, began talking about the need for fulltime, specialized, emergency physicians. The perception of these physicians is endorsed by the fact that today there is a specialty of emergency medicine with a college of over 9,000 physicians whose specialty has been recognized by the American Medical Association and the American Board of Medical Specialties.

As the concept of fulltime emergency physicians began to grow from a seedling thought to a tree of reality, the sophistication of an emergency medical system evolved to cause even more change. This change is documented by emergency rooms changing to Departments of Emergency Medicine, Trauma Centers, Cardiac Centers; from incidental part time emergency physician coverage to emergency medicine residency programs, emergency medicine specialty boards, and fulltime emergency medicine physicians; from station wagons to mobile trauma and cardiac units; from non-trained ambulance attendants to trained Emergency Medical Technicians, and paramedical trained ambulance attendants; from telephone communication to direct radio communication and telemetry.

Let us reflect that these changes in only fifteen years have been brought about because there was a medical need, a patient need, a community need, and the science of medicine responded.

Medicine, a dynamic science with an ever growing body of knowledge, is the hallmark of continual change in our society. This continual change has always ignited the medical profession to provide our fellowman and community with a perpetually advancing medical science. Emergency medicine is a part of that perpetually advancing medical science. Emergency medicine, a change, is a success story because it filled a need. □

ENZO V. DI GIACOMO, M.D.

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## HIGHLIGHTS OF EXECUTIVE COMMITTEE

The Executive Committee of the HDMS met on Monday, November 13, 1978 in the Conference Room of the HDMS.

Present were Drs. Flahive, Walthall, Remsberg, Fitzpatrick, Sachsse, Zadworny, Magill, Stoddard and Mrs. Purdy.

The minutes of the October meeting had been mailed to the members and they were accepted as read.

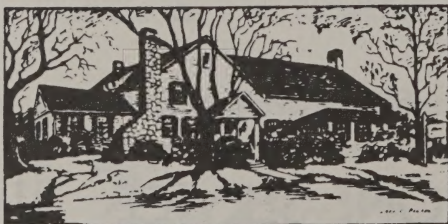
### CORRESPONDENCE

The Cancer Cooperative has invited members to their Annual Meeting to be held on November 29, 1978 at the Valley Bank Tower of Baystate West. Dr. Flahive will attend the meeting to represent the HDMS.

The Blue Ribbon Commission on Public Health Services mailed a thirteen page questionnaire to Dr. Flahive to answer and return to Mr. Joseph Roche, Chairman, by November 22nd so the Commission can compile information.

At the request of Palmer, Goodell and Keeney Insurance agents and after polling the Executive Committee, the HDMS wrote a letter supporting using local agents in the JUA. However, the attorneys, representing the independent agents, has informed them that the commission structure will not be amended. Mr. Goodell sent a thank you for the action taken by HDMS.

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The A.M.A. sent a brochure regarding the National Association of Medical Exploring which will recognize an outstanding medical explorer at the 1979 Annual Meeting of the House of Delegates. The local Boy Scout Association will be contacted for any suggested names.

#### **OLD BUSINESS**

Dr. Sachsse, Chairman of the Ad Hoc Telephone Listing Committee gave a report. No decision has been reached for HDMS advertising to be listed in yellow pages for referring and information concerning physicians in area.

The Board of Registration of Medicine answered the inquiry made to them last month by Dr. Walthall about advertising. They indicated that advertising by professionals has been ruled in the affirmative by the U.S. Supreme Court.

A letter from the WMHPC answering the inquiry made about a vacancy on the Board of Directors of that agency was read. Mr. Hooven indicated that the vacancy on the Board is to be filled by a dentist. He stated that in 1979 there would be a vacancy for a provider and HDMS might nominate someone to fill this at that time.

#### **NEW BUSINESS**

A letter from the Massachusetts Rehabilitation Commission was read and discussed. Mr. Lawrence, Director will be asked to write an article for the H.H. to inform the membership.

Further information on the New England Cardiovascular Health Institute will be obtained and such information will be sent to the membership.

The meeting was adjourned at 9:20 P.M. ☐

**WILLIAM W. WALTHALL, M.D.**  
Assistant Secretary

### *In Memoriam*

#### **OSCAR A. BOURGEAULT, M.D.**

Dr. Oscar A. Bourgeault of Holyoke died at the Soldiers' Home on October 16, 1978.

Born in Holyoke, he attended local schools and graduated from Georgetown University of Medicine in 1936.

Dr. Bourgeault served in World War II and was awarded the Asiatic-Pacific Theater Ribbon with two battle stars, the victory medal and the Phillipine Liberation Ribbon with a Bronze Star. He was a member of the A.M.A., The Massachusetts Medical Society and the Hampden District Medical Society for forty two years.

H.D.M.S. extends deepest sympathy to his son Paul and daughter Lynn as well as his many friends and associates. ☐

## *In Memoriam*

### LAWRENCE A. PUTNAM, M.D.

Dr. Lawrence A. Putnam of Holyoke died at Holyoke Hospital on November 9, 1978.

Born in Fairfield, Maine, he attended Colby College and graduated in 1929 from Boston University School of Medicine.

Dr. Putnam received his internship and residency in surgery at Massachusetts Memorial Hospital in Boston and received further study in surgery at the University of Vienna, Austria.

Dr. Putnam was President of Hampden District Medical Society for the year 1954-1955 and served as a Councilor of the Massachusetts Medical Society for twenty years. He served his country during World War II as a Navy Commander and was ship's officer aboard an attack transport in the South Pacific.

He was on the staff of Holyoke and Providence Hospitals as well as the Veterans' Hospital in Northampton.

Besides his medical career, Dr. Putnam served as director and Vice President of the Holyoke Y.M.C.A., held offices in the Second Congregational Church, and was on the Executive Board of the Mt. Tom Boy Scout Council and attending physician at Boy Scout meetings.

H.D.M.S. extends deep sympathy to his family and his many friends and associates. ☐

## *In Memoriam*

### EDMUND J. ZIELINSKI, M.D.

Dr. Edmund J. Zielinski of Holyoke died in Holyoke Hospital on November 13, 1978.

Born in Holyoke, he attended local schools and graduated from Holy Cross College and Jefferson Medical School in Philadelphia.

Dr. Zielinski was Medical Examiner for the third Hampden District for thirty seven years and was a favorite with news media and police departments where his prompt response to calls and cooperativeness was of invaluable assistance. He served his country with the Army Medical Corps as a Major during World War II.

Dr. Zielinski was a member of the American Medical Association, Massachusetts Medical Society, Springfield Academy of Medicine, and the Hampden District Medical Society which he served willingly and faithfully on committees.

Dr. Zielinski was one of seven boys in the Zielinski family and four of them went into the medical profession.

Deepest sympathy is extended to his two daughters, Karen and Donna and to his relatives and many friends. ☐



SINCE 1907

# SPRINGFIELD ACADEMY OF MEDICINE

TUESDAY, JANUARY 9, 1979

## "TEENAGE DEPRESSION AND SUICIDE"

**SPEAKER:**                    **LEO R. SULLIVAN, M.D.**  
Assistant Dean and Professor of Neurology

Dr. Sullivan is a graduate of Boston College and Tufts Medical School. He served internship at St. Elizabeth's Hospital, Brighton and residencies at St. Elizabeth's and New England Medical Center. From 1969-71 Dr. Sullivan was a NIH special fellow at Washington University Medical School, St. Louis, Missouri. Dr. Sullivan's appointments are: Assistant Professor of Pediatrics (neurology) at Tufts University School of Medicine, Pediatric Neurologist, at New England Medical Center Hospital and Assistant Dean for Students Affairs at Tufts University School of Medicine. Certified by the National Board of Medical Examiners and American Board of Psychiatry and Neurology (with special competence in Child Neurology) Dr. Sullivan is a member of the American Academy of Neurology, St. Louis Medical Society, Child Neurology Society, and the American Epilepsy Society.

**PROGRAM:**                    6:30 P.M.    Social Hour  
                                     7:00 P.M.    Dinner  
                                     8:00 P.M.    Lecture

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**RESERVATIONS:** Please call Mrs. Martin, 734-5445, before Friday, January 4, 1979.

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## HDMS SCHOLARSHIPS FOR 1978

On the recommendations of the Scholarship Committee, the following medical students were granted awards:

|                                   |                                               |
|-----------------------------------|-----------------------------------------------|
| James R. Laferriere<br>Chicopee   | University of Massachusetts<br>Medical School |
| Mary Anne Courtney<br>Westfield   | University of Massachusetts<br>Medical School |
| Mary Beth Hodge<br>Chicopee       | Tufts University School of<br>Medicine        |
| Christopher J. Schmidt<br>Holyoke | University of Massachusetts<br>Medical School |
| John J. Moynihan, Jr.<br>Holyoke  | Georgetown University<br>School of Medicine   |
| Ronald C. Holt<br>Springfield     | University of Vermont<br>College of Medicine  |
| Larry J. Markson<br>Longmeadow    | Boston University<br>School of Medicine       |
| Harold R. Jordan<br>Springfield   | University of Pavia,<br>Italy                 |

Loans to medical students from the Dr. Max & Ida L. Millman Foundation

|                                      |                                               |
|--------------------------------------|-----------------------------------------------|
| Robert C. Piela<br>Chicopee          | University of Massachusetts<br>Medical School |
| Marc E. Boisvert<br>West Springfield | Georgetown University<br>School of Medicine   |
| Elizabeth C. Rodgers<br>Chicopee     | University of Massachusetts<br>Medical School |
| Ronald C. Holt<br>Springfield        | University of Vermont<br>College of Medicine  |

# 1978 American Medical Association Auxiliary Leadership Confluence October 25-27, 1978 Drake Hotel Chicago, Illinois

**CONFLUENCE:** a coming together of people or things; assemblage. Come together we did...six hundred strong, the majority of whom were Auxilians, the rest a staff of experts assembled to teach and train. Seventy five per cent of the ladies were there for the first time, indicating a continuous turnover of new and interested people directing Auxiliaries all over the country. It was an exhilarating, revealing and learning experience which not only taught techniques and skills needed in running Auxiliaries, but also presented seminars designed as possible projects in our community.

The main themes running throughout the entire conference by both the AMA and the Auxiliary leaders were the need for Auxilians to be involved in legislation on health issues; the need to support the medical profession in its effort to control costs; the need to educate the community in the development of healthy lifestyles; and the need to unify our efforts towards strong membership.

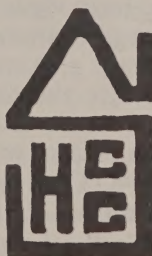
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Of necessity, the report here must be a capsule of each seminar but a longer and more complete version is available for use by members of either the Auxiliary or the medical society.

After hearing informative and rousing talks by Dr. Tom Nesbitt, President, American Medical Association and Dr. James H. Sammons, Executive Vice President, A.M.A., a national program briefing was presented by Auxiliary leaders on AMA ERF, legislation and membership. AMA ERF, the American Medical Association Education and Research Foundation awards unrestricted grants to medical schools, loans to medical students and residents and funds for research, scholarship programs and to improve quality and availability to medical care in the under-served areas. This year, funds raised are expected to be more than a million dollars. The legislative theme was "being informed is not a passive thing" and stressed our own responsibility in becoming informed on legislative issues. In view of present and future legislation in Congress, membership was presented as our #1 priority because indeed "in unity there is strength." On all three subjects, techniques and guidelines were graphically demonstrated to achieve our goals.

Ten seminars were conducted by experts: four were designed to strengthen leadership abilities and six as possible Auxiliary projects. The following are condensed reports.

#### **Future Planning: Long and Short-Range**

Mr. Bruce Balfe, Director of the AMA Department of Long-Range Planning discussed the advantages and disadvantages of having a Long-Range Planning Committee. Advantages are: the group can sit back and take a long-term view; it can screen ideas and it functions as a unit within the organization which can look into things. The disadvantage is that a Long-Range Planning Committee could conceivably conflict with the Board. When considering a new project, we should determine community needs and membership needs. The reasons people join a project were discussed and a formula for success was presented:  $QUALITY \times ACCEPTANCE = SUCCESS$ .

#### **Parliamentary Procedure**

This was specifically designed to help state and county auxiliary leaders on problems of presiding and the preparation of agenda items at

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meetings. The group was led through a mock meeting and discussed reports, motions, resolutions, and the amending process.

### Priority Legislation

Because of government's increasing involvement in health care and the intention of the administration to control the health care industry, a significant percentage of the AMA budget goes to legislative activity. A major activity is to study a non-federal approach to national health insurance. The AMA has had its own bill in Congress since 1970. An overview of legislation in the recently adjourned Congress revealed bills on hospital cost containment, drugs, child health assessment programs, clinical laboratories regulation, health planning (Certificate of Need extended to the Physician's office) and extended federal support for health related subjects. Next year, bills will be filed on the same issues along with additional ones on control over geographic and specialty distribution of physicians, and national certification of physicians.

### The Art of Public Relations

This was a well-conducted presentation of guidelines to be used by the Auxiliary with the media and the art of using public relations as a public education tool since we in our community should be well qualified to tell about health education and care. It stressed "singing our own song" with members of physicians' families sharing in the betterment of health. This program was technical, informative, practical and of great value. There is much resource material available here.

### Alcohol and the Teenager

Children should be told about alcohol early in life...before high school certainly. Because alcohol is a socially acceptable drug and one that is more readily available than others, the danger of becoming dependent upon it is far greater. This seminar focused attention on two needs: first, the need to identify the child who is drinking and second, the need to identify the children of alcoholic parents.

### Developing Healthful Lifestyles

Disease prevention, health protection and health promotion are words we hear frequently these days. In the future, each of us will be encouraged to take personal responsibility for our own health. We heard about Health Hazard Appraisal (HHA) which is based on probability tables made from U.S. death rates and known risk factors. Using a



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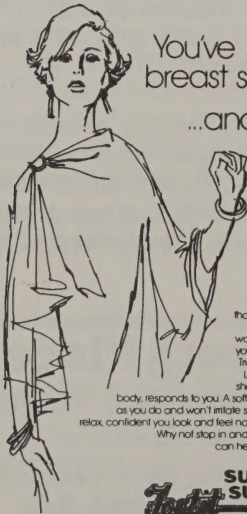
computer, a patient's disease risks and life expectancy can be calculated. Also, it can be calculated by what degree his life expectancy can be improved by a change in habits. Actual application of Health Hazard Appraisal was described by Sabina Dunton, MPH, Director, Well Aware About Health, University of Arizona.

### Emergency Medical Services

Dr. Robert W. Gillespie, member of the AMA Commission on Emergency Medical Services, spoke to us, emphasizing that a community's emergency medical services should be organized in a comprehensive and systematic fashion. It should include the necessary components of: prevention, detection, notification, dispatch, treatment, transportation, emergency departments, in-hospital care and rehabilitation. Dr. Richard Moriarty, Director, National Poison Center Network, Pittsburgh, Pa., discussed the management of poisonings in a hospital emergency situation, with suggestions for Auxiliary involvement.

### Health Planning -Public Law 93-641 (1974)

This was an educational seminar informing us of the widespread effect this law will have in physician's practices for the next twenty years. This is the law which was responsible for setting our own Western Massachusetts Health Planning Council. It is a very complex law in construction, derivation, implementation and its effect on the future. It also presents an opportunity to improve our medical system. Two very effective examples of both medical society and Auxiliary involvement with the local application of this bill (in Minnesota and Texas) were given to show the importance of Auxiliary members as resource people. It was also stressed here that AMA is not opposed to health planning



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but to the regulatory mechanism of so many bills introduced in Congress.

### Hospice Concept

This outlined the philosophy of care for people with long, chronic illnesses and the very specialized care available to patients with terminal illnesses. It can be applied in institutions, hospital or at home. It is a way of caring for sick people using an interdisciplinary approach. It not only involves specialized training for those who care for sick people but also has a program of bereavement counseling as well. A historical background of this movement was given and the renaissance of this concept in the U.S. showed a most interesting and humane health care concept with a good chance of development into a viable program in total management of the long term chronically and terminally ill.

### Upgrading of Jail Medical Care is Cost Effective

This was a report on the pilot program to improve medical care and health services in jails, sponsored and staffed by the AMA, financed by a grant from the Department of Justice. The long range objective is the development of a national accreditation system for jail medical programs with the ultimate aim of improving delivery of medical care and health services to inmates of the nation's jails.

A final quotation: "To acquiesce in our responsibility toward solving health care problems is to forfeit our right to make decisions concerning those problems and to allow passage of poor laws is to break faith with the people who look to the physician for his guidance in health care matters."

This was the theme of the entire confluence.

Thank you for letting us represent you. □

**POLLY MILLER, President**  
**JEAN MEDREK, President-Elect**

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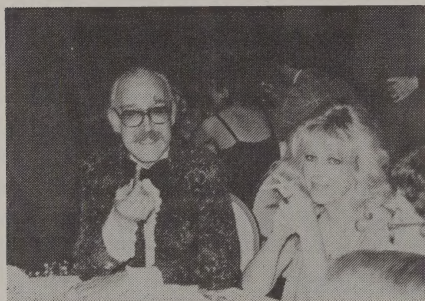
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## TWENTY SIXTH ANNUAL WHITE CAP BALL Marriott Hotel

Rarely are auxiliaries and their husbands afforded the enchanting ambience of a splendid repast and agreeable company. The recent WHITE CAP BALL met these expectations for an exciting evening of dinner, dancing and good fellowship. Chairwomen Francoise Pelletier, Del Chabot and Arlene Corsaro gave unstintingly of their time and resources during the preceding months to ensure the success of the event. Mrs. Salvatore Sannella and Mrs. Frank Stein helped welcome guests, and our membership provided excellent support for this worthwhile scholarship effort. □



**HELEN K. GALLIVAN**  
Auxiliary Representative  
to the Hippocrat

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# Physicians' Effectiveness Program [PEP] Ohio State Medical Association [OSMA]

## I What is PEP?

It is a program for identifying impaired physicians and inducing them to accept evaluation and treatment.

It is concerned with the sick rather than the incompetent or malicious practitioner - it is a helping rather than a punitive program.

It provides three options.

### Option 1. Individual Initiative.

A physician recognizes he has a problem, seeks our assistance, and we help him find appropriate treatment. No records are kept.

### Option 2. Peer Initiative - Sick Physician Agreement.

Colleagues report to us their concern about an impaired physician with the assurance that they remain anonymous. After verification of facts, the physician is sent a letter informing him of three things:

- a. that we have learned he may have a problem;
- b. that we have a program to help him deal with it; and
- c. that a concerned colleague will call upon him in the near future to discuss this. Colleagues performing this voluntary service are referred to as District Liaison Physicians (D.L.P.). Then, the physician is visited by the DLP, is apprised of the facts, and is offered assistance in finding treatment. Once he is in treatment, OSMA withdraws. No records of the transaction are made.

### Option 3. Peer Initiative - Sick Physician Refusal.

Here, the procedure is identical with Option 2 up to the point where the physician denies the problem, refuses our help, and/or fails to seek treatment.

Then, the DLP reports back to the Chairman of PEP who writes the physician another letter reminding him of our responsibility to notify the Ohio State Medical Board of the problem unless he changes his mind and accepts treatment. The DLP follows this up with a telephone call.

If the physician still fails to comply, the State Board is informed that we believe he is impaired. At this point, OSMA withdraws. No records are made.

## II Why have such programs?

First, we must be aware of the very real legal liability we face if we permit an untreated, impaired physician to continue practicing once his problems have surfaced. Attorneys are aware of this and the associates of impaired physicians (partners, hospital staffs, etc.) have been included in malpractice suits under such circumstances.

However, it is my sincere conviction that those who originated our program were motivated primarily by ethical principles - by sincere concern for the public (our patients), for the physician, and for his family. Were it otherwise, I would not be spending my efforts in this work. I believe the medical profession is a brotherhood and I am my brother's keeper.

### III Whom are we trying to reach?

Other mechanisms are available for dealing with the inept, the incompetent, and the malicious physician. Our program is directed at the **impaired physician** - the otherwise competent practitioner who is impaired by such things as failure to recognize his own physical disability, by senility, by psychiatric disorder, or by alcoholism or drug addiction, the latter being the two commonest causes. Most are physicians of high caliber and integrity. Impaired self-perception is their hallmark. Their problems may even stem in part from their dedication to our profession.

Bittker(1), writing about depressed physicians, said, "Many of the character traits that contribute to physician success become risk factors for depression when amplified. The qualities of self-sacrifice, perseverance, competitiveness, and even, to some degree, denial of feelings are essential for the passage of the physician through the stages of student to mature professional."

There is no room here for the moralistic, judgemental attitudes that often impede discussions of such problems. We are concerned here with sick physicians rather than bad physicians!

### IV What about Attitudes?

If we are not positive and compassionate, our Program cannot succeed - sick physicians will not be salvaged and returned to happy, productive lives. We must be able to see the often obnoxious and deceitful behaviour of the impaired physician as a manifestation of sickness rather than badness. His own denial mechanisms stand in his way and others close to him may participate in the denial. For these and many other reasons, we may be tempted to reject him. Such temptations must be avoided. Bittker wrote further. "Notoriously reluctant to seek help, the emotionally disturbed physician presents an enormous challenge to family, colleagues, and therapists. Since many of his defenses have been mobilized to deny awareness of his dependency needs, the physician may seek treatment only when his capacity to practice is imperiled. Reluctance is further magnified by realistic fears of stigma associated with the role of the psychiatric patient."

### V How do we go about it?

From the outset, we must recognize that our best efforts may not succeed. Some of our colleagues may remain sick, may harm patients, may further disrupt their personal lives, and some may die. Since this is a chancy endeavour, I employ the acronym DICE to designate the four phases of intervention - Detection, Investigation, Confrontation, and Education or Expulsion.

**DETECTION.** Mechanisms are available for detecting impaired professional performance, but such impairment often is not evident until late in the course of illness. Patient care has already been affected. Long before this, his family and close friends have known the physician was in trouble. They, however, share in the game of denial. Not being aware of the inevitable and relentless progression of his problems, fearing disgrace and financial disaster that might result from disclosure, and just simply hoping things will somehow work out, they keep silent and their sickness progresses along with his. If family, colleagues, and other friends can recognize and accept the reality of his illness, if their attitudes are positive and compassionate, and if they can learn that most

sick physicians can be effectively treated, then we can offer hope to them and to the physician-patient.

**INVESTIGATION.** People working in this program must be mature. They must be endowed with qualities such as empathy, wisdom, patience, and faith. Reports of impairment must be verified and facts must be assembled as quietly and anonymously as possible. Lives and careers are at stake, not to mention the preeminent concern of patient welfare.

**CONFRONTATION.** Confrontation of the impaired physician with the facts of his illness requires an attitude of firm kindness sometimes called "tough love." The object of confrontation is to overcome our sick colleague's denial by bringing him messages from reality. Then, he may become receptive to treatment. Here is where empathy, wisdom, patience, and faith are put to the test. We may fail and it may be necessary to repeat the confrontation again and again until that time when the chaos of his life is so painful that he will surrender and comply. Meanwhile, he and his family will suffer a great deal and he may well die by suicide, by accident, or by the late effects of his illness or addiction. We may fail, but at least we tried!

**EDUCATION or EXPULSION.** If the impaired physician will not accept treatment (i.e. education), action must and will be taken to prevent further injury to his patients, his family, and himself. Our Program provides for notification of the State Board.

Otherwise, we can offer him hope. Hope must be transmitted to the impaired physician beginning with the moment of confrontation and must be shared by those confronting and attending him. Just as we cannot assume he knows he is sick, we cannot assume he knows his sickness is amenable to treatment or where or how to obtain it. Little good will come of simply advising him to seek treatment. If he were capable of making good judgements and reliable decisions about himself, it would not have been necessary to confront him. We must know that he can have a better life, we must know what a proper treatment is, and we must know where and how it can be obtained. Then we must take him there. Once there, willingly or by coercion, he has a chance for recovery -- hope.

---

Reference:

1. Bittker, T.E.: Reaching Out To The Depressed Physician.  
JAMA 236: 1713-1716, Oct. 11, 1976.

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## UNDER THE TREE

[For the kid who has everything]

News item: Denver (UPI) Youngsters should replace nursery rhymes about tuffets and mice with the saga of a calculator and verses about liberated parents, says California psychologist Fitzhugh Dodson. Dodson believes that the messages children receive from traditional nursery rhymes are out of date, irrelevant and sexist.

The Morning Union Nov. 10, 1978

Ding Dong Bell  
Pussy's in the well.  
If perchance it kilt her  
Chlorinate and filter.

Pussy cat, pussy cat  
Where have you been?  
Who the hell cares  
If ya know what I mean?  
Hickety, pickety, my black hen,  
She lays eggs for gentlemen,  
But gentlemen both great and small  
Fret about cholesterol.

There was a young woman  
Who sailed with a crew,  
But don't be concerned  
She knew just what to do.  
When they landed in port  
She took off for the hills.  
The reason was simple  
She ran out of the Pills.

Jack and Jill  
Went out to kill  
A fifth of Scotch and soda.  
But instead of having fun Jill got nasty  
And Jack had to have a cranioplasty  
Before they drank their quoda.

What the computer is all about  
Is garbage in and garbage out.

Now. mother, don't get in a stew,  
I wouldn't want to worry ya.  
It's NGU not PKU  
That's phenylketonuria

When the Dow breaks  
The market will fall  
And down will come traders,  
Brokers and all

But low, baby.

HNS

## Yuletide

Again we have Yuletide!  
Thank God we're still alive  
To pray, to love, to strive  
For goals supreme and wide.

This is the time to sing  
Great hymns of hope and joy;  
To use and then employ  
Our strength to make peace ring.

O Christmas, do remain  
Tenaciously with us.  
The signs which are all plus  
Are found in your domain.

You stand and always stood  
For freedom, justice, light,  
Salvation, promise, might  
And man's true brotherhood.

O Yuletide, give the best  
To our research. Good health  
Is greater than all wealth  
"Et suprema lex est".

JOHN J. ALIFANO, SR. M.D.



# OLDER AMERICANS ACT AMENDMENT

On October 18, 1978, President Carter signed the 1978 Older Americans Act Amendments. This law is one of the major funding sources for services to older Americans, and the law established a number of new provisions which would be of interest to the general public and medical community. These new provisions are:

**Nutrition Program:** The establishment of a Home Delivered Meals service that addresses those elderly who are frail and cannot go to a congregate meal site. Congress proposes to allocate 80 million dollars in FY 79 for such a program.

**Special Projects in Long Term Care:** The bill authorizes the Administration on Aging to fund State Agencies, Area Agencies and non-profit organizations to support the development of comprehensive, coordinated systems of long-term care for older persons. This system would include adult day health, monitoring and evaluation of service effectiveness, supported living in public and private non-profit housing, family services; preventive health services, home health, homemaker, and other rehabilitative and maintenance in-home services; and geriatric health maintenance organizations. The intent of this provision is to support the development of comprehensive, coordinated systems of long-term care for older persons.

**Reduction of Paperwork:** Congress agreed to direct the Commissioner on Aging to undertake necessary actions to reduce the paperwork burden on State and Area Agencies on Aging.

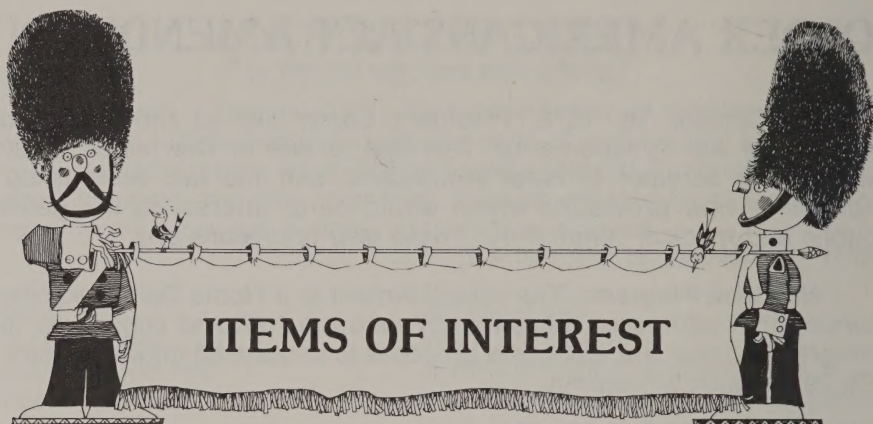
**Consolidation:** Congress authorized a new comprehensive T-III, consolidating former Title VII (Nutrition), T-V (Multi-purpose Senior Centers) and T-III (Social Services) with separate authorizations for social services, congregate meals and home-delivered meals.

The overriding intent of the new amendments is to provide a better means to manage the planning, coordinating and services to older people throughout the country. During the next three years, the Aging Network will have an opportunity to implement the intent of Congress at the local level. □

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## ITEMS OF INTEREST

**AMA witnesses** told the Senate Human Resources Subcommittee on Health that the national health insurance plan developed by Sen Edward Kennedy (D-Mass.) and organized labor would result in a "federal takeover" of the health care system and would "not be in the interest of the citizens of this country." Speaking for the AMA were James H. Sammons, MD, executive vice president, and William C. Felch, MD, chairman of the AMA Council on Legislation. "We do not think the American public will want its health care directed and controlled by the federal government," Dr. Felch said. "The history of federally run programs does not instill such trust and confidence as to support such action." Another witness, HEW Secretary Joseph Califano, said the plan was too costly, pointing to the \$30.8 billion it would add to the federal budget by 1983. Any program, Califano said, "must be phased in with singular care and sensitivity to the economy, governmental budget, and the administrative complexity of the health care system."

**Members** who choose to work under contract to hospitals rather than practice on a fee-for-service basis will not be penalized, the American Society of Anesthesiologists agreed in a consent order. A Federal Trade Commission complaint charged that the society's "Guidelines for the Ethical Practice of Anesthesiology" and a "Statement of Policy" advised members that they should be compensated only on a fee-for-service basis and should not practice as salaried employees of hospitals or other organizations. The FTC said the consent agreement does not constitute an admission by the society of any law violation. Under the order, the FTC said, the ASA must delete from its files "any record of censure" against members for past failure to comply with the policy.

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**"Medicine-A Global Discipline,"** will be the theme for the 75th Congress on Medical Education, May 9-13, at the Washington Hilton Hotel, Washington, D.C. The meeting is cosponsored by the AMA's Council on Medical Education, the Assn. for Hospital Medical Education, the Federation of State Medical Boards of the U.S., the AMA Resident Physicians Section, the AMA Section on Medical Schools.

**Revisions** to the physician's Current Procedural Terminology are available. The new update to the book, published by the AMA, includes changes and additions to the terminology in the fields of surgery, vascular studies, and medical service procedures. Also added are terms for bio-feedback training. Updates may be obtained by using a prepaid mailer in the back of the book.

**"The design** of the voluntary effort addresses the unique problems of its own field better than any other effort the Council on Wage and Price Stability has seen," COWPS chairman Barry Bosworth told a meeting of the Voluntary Effort Steering Committee last week in Washington, D.C. The VE was organized by the American Hospital Assn., the Federation of American Hospitals, and the AMA late last year with a goal of reducing the rate of increase in hospital expenditures by 2% a year for the next two years. During the first seven

months of 1978, the rate of growth of hospital expenditures was the lowest since 1974. "Hospitals are one of the very few industries in which deceleration has succeeded," Bosworth said, "and this is significant considering the rate of inflation in the rest of the economy."

### **Radiologist's Purchase Of Cat Scanner Not Subject To Certificate Of Need**

A radiologist's purchase of a CAT scanner for his private office did not require a certificate of need under the Health Care Facilities Planning Act, a New Jersey appellate court ruled.

The state Commissioner of Health concluded that the purchase of a CAT scanner constituted construction of a health care facility and required a certificate of need. The Commissioner based her decision on the large expense associated with purchasing and operating a CAT scanner. The radiologist filed suit challenging the ruling and contending that the Commissioner had no authority to regulate his private practice. The appellate court agreed and reversed the Commissioner's decision.

The act clearly indicated its objective was to control institutions such as hospitals and similar facilities. The definition of health care facility did not include a physician's private practice, the court said. -- Marsh v. Finley, Docket No. A-742-76 (N.J. Super. Ct., App. Div., June 15, 1978)

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